

PPIP6 Reflective Essay

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PPIP:

Application of professional, ethical and legal principles in clinical practice.

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In this essay I will be exploring my application of professional, legal and ethical principles in practice. I will be using Driscoll's (2007) reflective framework to analyse an incident from practice, with regards to any issues it has raised and how it has influenced my professional development as a nurse. I first discussed this incident with my clinical mentor and the staff team, before bringing it to a syndicate meeting for discussion with my academic tutor and peers.

The incident occurred during my time working with a specialist community mental health team: During a home visit the partner of a service user (SU) under our care disclosed in privacy that the SU had become increasingly aggressive towards her and that he had at times become violent and forced himself on her sexually. She did not want to speak to police and declined offers to take her to a place of safety. The member of staff present explained that they had a responsibility to pass this on as a safeguarding concern and she agreed to this but requested that her partner not be told that the information had come from her. This was passed on to the police as well as the trust safeguarding team and after further investigation the SU was taken into custody, but later released after the partner retracted her statement. Following this incident the SU refused to engage with the team any further due to the part they played in his arrest. The team gathered together and discussed this incident to debate on how to move forward; they had a responsibility to provide care to the SU, particularly as he was subject to a community treatment order (CTO) and police had reported a decline in his mental health whilst in custody, however the present breakdown in their therapeutic relationship meant that he would not allow them into his home or speak with staff through other means. Unfortunately I was not able to see how this incident continued as my time on the placement ended, however being involved in these discussions allowed me to highlight and discuss with staff some of the key issues which they were facing and so I will be analysing some of these in this essay.

The incident raised many issues, but in discussion with my clinical mentor we agreed that in this situation the key aspects to focus on were: The responsibility of staff to report any safeguarding concerns even when asked not to, and their responsibility in safeguarding not only their SU's but also the wider public, the impact of doing this on their therapeutic relationship with the SU and finally the balance between responsibility to provide care and respecting the SU's wishes with regards to him not wishing to engage with the team. I will be breaking these issues down into the professional, legal and ethical aspects of each and exploring what local/national policy and relevant literature says on each area.

Firstly I will explore the professional aspects of these issues; The Department of Health (2011) states that nursing staff have a professional responsibility to safeguard their service users, particularly those who are more vulnerable. In this case it was deemed that both the SU and his partner were vulnerable, and as such the actions taken safeguarded both of them in different ways: Had the incident not been reported staff may have been leaving the partner may at serious risk of further abuse/violence. Many studies have explored the area of repeat domestic violence; one such report by Walby and Allen (2004) found that two-thirds of the women in their study had experienced more than one incident of abuse in the last year, and that for more than half of them this was their first time reporting. The staff were aware that historically the SU had become aggressive when his mental health was in decline, and that the stress of police involvement posed risks of him rapidly becoming unwell and more violent – putting his partner at risk. In discussion as a team we agreed on how reporting this incident safeguarded the SU, as the abuse may have escalated and

intervening now could have prevented him from committing a much more serious act against his partner or the public. Making the team aware of what was disclosed prompted them to reassess his current mental state and the effectiveness of the treatment they were providing. Guidance by the Royal College of Nursing states that nurses must 'report concerns' and 'share appropriate information with other teams' (Garrett, 2007), in this case the information was disclosed to an individual member of staff who then made the judgement to pass this on to not only the rest of our team but also the police and trust safeguarding team. The NMC code of conduct (2015) is clear that nurses must 'act without delay' when they believe a person or the public is at risk, the whole incident described took place over one working day and I feel the speed of response to this demonstrates the effectiveness of the team and wider trust in safeguarding people at risk. In addition the Code states that nurses must 'take all reasonable steps to protect people who are at risk from abuse' (NMC, 2015), the nurse involved immediately offered to take the partner to a place of safety and although this was declined she passed information onto her allocated support worker to ensure that she was found a safer place to stay long term.

Looking at the issue of the SU refusing to engage with the team there were some professional issues around this. Firstly, individuals have the right to accept or refuse care or treatment (NMC, 2015) and an aspect of the professional responsibilities of a qualified nurse requires us to respect and support such wishes. However the Mental Capacity act (MCA, 2005) deems that if a SU lacks capacity then at times this principle must be overridden and decisions must be made on their behalf. These should always be made in the best interests of the individual (Mental Capacity Act, 2005), and so in this situation there needed to be a universal agreement on how to progress with providing care. This is discussed in more detail further on.

As a student nurse I am also expected to work within the framework of the NMC Code (2015) and so work within the limits of my competence. For this reason my role in this incident was to observe the actions of qualified staff and participate in discussions. This was beneficial to me being able to see and further understand the roles which each person played, the range of professionals within the wider trust team who were involved. The NMC Standards for Pre-Registration nurses (2010) emphasize the importance of understanding the roles played by other professionals and working collaboratively with them in providing care. The downside of this is that as a student working towards professional registration I want to be as involved as I can in all areas of practice, and so at times I found it frustrating to simply observe. However, I am able to understand that this was not within my competence and so respect the decision made about my involvement.

The Department of Health (DOH) Care Act (2014) gives a clear legal framework for protecting adults at risk of abuse. It highlights the need to share information with relevant people to protect the person at risk, and gives clear guidance on circumstances when this should be done even when the individual requests otherwise (DOH, 2014). In this situation the partner had requested that the information not be passed on, as far as staff were aware she had the capacity to decide this. However guidance in the Care Act (2014) outlines the need to share information when the abuser themselves have care and support needs, or when it could potentially lead to a serious crime. Staff were concerned that whilst this was already a serious incident there was potential for the level of violence to escalate very quickly. Walby and Allen (2004) found that the highest rates of repeated serious incidents were seen in non-married intimate relationships, such as that of the individuals in this

situation. The staff were aware that the SU could become more aggressive should his mental health decline, and so felt it was necessary to share what she had disclosed to protect them both.

The common law duty of confidentiality (DOH, 2007) challenges staff to 'carefully consider the risks of sharing information related to domestic violence', as there was concern that the partner would be at greater risk having disclosed this information it was important to involve the partners allocated worker as well. In situations such as this when information must be shared staff are expected to follow the Caldicott Principles (HMG, 2015); sharing minimal confidential data and only as much as is necessary, so as to continue to protect patient confidentiality. For example: in this case it was necessary to share information with the police regarding the SU's mental health and the fact that we were his care team, ensuring that we would be kept updated and that if needed whilst in custody they would not hesitate to contact the team and provide mental health support for the SU.

Another legal issue faced by the team was the SU disengaging following his arrest. He was subject to a community treatment order under the MHA (1983), which requires an individual to comply with certain terms regarding medication, therapy, management, etc. whilst living in the community (Mental Health review Tribunal, 2013). Under a CTO a person who does not engage with these terms could be recalled into hospital for treatment, should staff feel it is necessary (MHRT, 2013). This aspect of CTO's safeguards individuals to ensure that if needed they can access acute care quickly, however it does require SU's to trust that staff are acting in their best interests. The Department of Health's policy on safeguarding adults (2013) outlines one of the key safeguarding principles as 'proportionality', that staff will always work based on best interests and be only as involved as needed.

Whilst the staff felt that up to this incident the SU's mental health had appeared stable and he had complied with medication there was now concern that he would decline without support. Additionally they had a legal and professional obligation to continue visiting and attempting contact with the SU. This was an aspect which they planned to explore in the following days as they waited to see whether he would agree to see them after a period of 'cooling down', and accept his medication from them when due. Had I been with the team for longer it would have been useful to see the process involved in assessing whether an individual requires recall under their CTO, and so this is something I plan to explore with clinical mentors in future practice.

Finally I am going to explore some of the ethical dilemmas which were faced in this incident. One issue which the staff particularly struggled with was the SU's decision that he no longer wanted to engage with the team following their involvement in his arrest. On the one hand principles such as those set by Beauchamp and Childress (2001) are clear that promoting and maintaining autonomy is a vital aspect of providing care, by allowing them to make decisions about the treatment they receive. However as discussed earlier the SU was deemed not to have capacity to make these decisions, and was under the restrictions of a CTO. For me this posed an issue in how we can be respecting the autonomy of a SU if we are making decisions for them, albeit in their best interests. The code of practice (DOH, 2015) which was published to support the Mental Health Act (MHA, 1983) discusses how staff can preserve autonomy by choosing the least restrictive actions when making a decision on behalf of a service user. In addition, I found that the Department of Health's safeguarding adult's guidance (2013) explained the importance of empowerment in these situations, that all parties involved are given information on what is being done, what support is available and that so much as possible they will be consulted before taking any actions.

This helped me to see how I could in future support individuals who may lack capacity in these situations.

In terms of actually making these decisions there was some conflict within the team; staff had previously had a strong therapeutic relationship with this SU and so there was concern that the relationship could break down entirely. They planned to attempt to see the SU on his next visit day and assess his response to them in person. Should he still not want to engage one solution to this could be to suggest a period working with another team, such as an intensive community service, to ensure that the SU is still receiving necessary care and support, although this would still require him to agree to engagement with an alternative team.

Another issue which we discussed as a team was the idea of culpability. In some cases it is necessary to determine whether or not a person can be held responsible for their actions, or whether those actions were as a result of their mental ill health (Crown Prosecution Service, 2015) I feel that such situations highlight how important it is how well a team knows their SU's; in this case the team were aware that on the one hand the SU had a history of violence/aggression when he was becoming acutely unwell. However the partner had reported that his actions towards her had been going on for a significant period of time, and so staff felt that the aggression towards his partner was not linked to any recent decline in mental state. This is an aspect which I struggled to find relevant literature on, many studies focussed on the effect on mental health of experiencing domestic abuse as opposed to situations where the abuser themselves were unwell. I plan to continue my literature search in this area and speak with relevant staff who may have professional experience which I can draw on to help me in my continuing development.

Having reflected on the ethical aspects of this incident I feel that the actions which were taken demonstrate the values which are held by the staff team; they were compassionate towards both parties in this situation, and all decisions made were in their best interests and to protect the wellbeing of both individuals. In discussion it was clear that all involved empathised with the difficulties faced by both the SU and his partner. These are in line with the values of the local trust, which include the provision of 'compassionate care' and 'working together' to put people first in all they do (Leeds, 2010). Throughout my training I am continually exploring and developing my values as a professional, I feel situations such as this help me to see where my values lie and how they line up with those of my team and local trust.

I have reflected on this situation using Driscoll's (2007) reflective framework; this I chose because it is one which I am familiar with and I find is particularly effective in highlighting the key relevant information from a situation, allowing me to be more concise and focussed in my discussions.

Being involved in this incident gave me an opportunity to observe the process staff follow when faced with safeguarding concerns, as well as being involved in team discussions which analysed the actions taken, what could have been done differently and how to move forward with the SU's care given the effects it has had on the therapeutic relationship. This in particular I felt was beneficial as I could see how the staff team reflected on their own actions and supported each other in a difficult situation. Durgahee (1996) found that this type of reflective practice actually led to positive changes in practice and improved critical thinking. Additionally, The NMC's standards for pre-registration nurse education (2010) state that we

should be able to recognise and address ethical challenges regarding care decision making, and so I found this a useful experience in developing this skill. It was unfortunate that I was not able to see what conclusion was reached, but nonetheless being involved provided me with useful experience which I feel I could use if faced with a similar situation in a different team.

The analysis which I have conducted afterwards has allowed me to develop a more thorough understanding of the legal framework which underpins my actions to safeguard people in practice, as well as helping me to highlight particularly relevant literature and guidance which I can refer to when debating how to respond in future. The importance of this is set out in the NMC's standards for pre-registration nursing education (2010), stating that mental health nurses must understand and appraise evidence in practice, and discern where to apply such theory to my work.

In my future practice I hope to take this learning forward by continuing to appropriately safeguard those in my care, and contributing more to discussion and reflection within the staff team, consulting others whenever I'm involved in issues such as this. I hope to evaluate how adeptly I have done this by seeking feedback from other members or staff on whether I acted appropriately and ways I can continue to improve. This was an incident I faced as a student, and as such I was not involved in the decision making any deeper than participating in discussion. Given that I will soon be a registered nurse I felt it was useful to spend time reflecting on their role in comparison, and the leap in responsibility which will come with that. This is something I want to explore more with my clinical mentors in future practice.

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